

TERMINATION NOTICE TO DIOCESE OF CALIFORNIA

Today's Date: _____ Prepared By: _____

Employing Entity: _____ Parish Code: _____

Employee Name: _____ Last Day Worked: _____

****When is final check owed? :**By the end of the work day on date of termination. Accrued vacation benefits must be paid as wages with final paycheck. (Cal. Lab. Code §§201, 202 and 227.3) If final day of work falls on payday you may process final check with regular payroll see option 2 below

Remove Employee From Benefits (employees working 20+ hrs./wk have benefits)

Effective Date (coverage continues thru the final day of the month indicated): _____

Employee working 20+ hrs/wk must be provided Salary Continuation information:

YES we provided the information & forms to the employee on date of: _____

Employee working 30+ hrs/wk must be provided Medical Continuation information:

YES we provided the information & forms to the employee on date of: _____

The employee has 30 days from termination date to apply for Salary or Medical Continuation

Remove Employee From Payroll

1) To issue a manual check on day of termination: Call the payroll office, 415-869-7805, to report the gross pay (inclusive of the value of any accrued vacation benefit). We will provide you with the appropriate tax deductions and net pay of the final check you are to issue to employee. Fax a copy of the final check along with this notice to the Diocesan Payroll Office: 415-673-4863

Gross Reg. Pay: _____
(inclusive of accrued vacation benefit)

Housing: _____

FIT deduction: _____

Fica deduction: _____

Medicare deduction: _____

SIT deduction: _____

Lay Pension deduction: _____

Flex Spending deduction: _____

Misc deduction: _____

Net Pay: _____

OR if final day of work falls on pay date you may process final check with regular payroll

2) Process final paycheck with regular payroll on this date: _____

Indicate any amount of pay to be added (+) or deducted (-) from the usual payroll on the timesheet

Signature of Authorized Agent: _____

Contact Phone: _____ **Contact Email:** _____

Instructions for Continuation of Medical Coverage

**(NOT TO BE USED BY CANONICALLY RESIDENT CLERGY
PLEASE CALL BENEFITS OFFICE FOR CLERGY FORMS & INFORMATION)**

The Diocese of California **does not have COBRA** obligation under federal laws and regulations. However, we have elected to provide a Continuation of Coverage option for our employees and their eligible dependents. The following outlines the basic provisions of this policy.

1. Medical Continuation does not apply to canonically resident clergy. Cleric should contact Sarah Crawford for information & forms to continue medical, dental, life & EAP coverage.
2. Only medical and dental coverage may be continued and this coverage must be in place at the time of the termination of your employment. Only those dependents covered at the time of termination may be covered under this policy.
3. In most cases, continuation coverage lasts for a maximum of 18 months. However, if you are totally disabled, the continuation coverage will be extended from 18 months to 29 months.
4. **The terminated employee pays the cost of the coverage.**
5. You must complete the attached Continuation of Coverage enrollment form and return it to the Diocesan Treasurer's office within 30 days of your termination date. Failure to comply with this provision will end your eligibility for continuation of coverage.
6. **If premiums are not paid within 30 days of their due date, coverage will be terminated retroactive to the last day of the period for which premiums have been received.**
7. You may cease coverage by notifying the diocesan administrator in writing of your decision. **Notice must be in writing.** Coverage will be terminated at the end of that calendar month.
8. All correspondence about this policy must be addressed to:

Diocese of California Benefits Administrator
1055 Taylor Street
San Francisco, CA 94108

9. For questions, please call, fax or email:
Sarah Crawford, Benefits Coordinator
Ph: 415-869-7805
FAX 415-673-4863
Email sarahc@diocal.org

MEDICAL CONTINUATION ELECTION FORM – FOR LAY EMPLOYEES ONLY

**(NOT TO BE USED BY CANONICALLY RESIDENT CLERGY
PLEASE CALL BENEFITS OFFICE FOR CLERGY FORMS & INFORMATION)**

Employer: please indicate employee's current medical coverage and premiums in the shaded section of the form

Notice Date: _____ Prepared By: _____

Former Employer: _____ Termination Date: _____

Dear (employee name) _____:

Former employees are eligible to continue their current health benefits at their own expense for up to 18 months through the Diocese of California. Your current medical ins. is with:

_____ monthly premium of: _____

To continue coverage, you must respond with payment for your first month's insurance premiums within **30 days from your termination date**. You will be billed for your monthly premiums thereafter. Your monthly payment is due by the first of each month, *whether or not you receive a bill*.

If you wish to continue coverage, please read the instructions (previous page) and the statement below, sign it, then send this letter and a check to cover one month's premium to: The Diocese of California, Benefit's Office, 1055 Taylor Street, San Francisco, CA 94108.

I wish to continue this coverage at my own expense, and have enclosed payment to cover the cost of my first month's premiums. I understand that the Diocese must receive this notice and payment within **30 days of my termination date**. I further understand that future payments will be due on the first of each calendar month.

During my previous employment I received and wish to continue the following benefits under the Diocesan plan:

I accept continued Medical Coverage: Yes No (premium listed above)

I accept continued Dental Coverage: Yes No Premium: Single \$62.78 Dual \$115.34 Family \$169.30

Signed: _____ Date: _____

Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Salary Continuation Benefits Program (for lay & clergy)

PURPOSE:

To provide full-time (20 hours or more a week) lay and clergy employees a Salary Continuation Benefits Program intended to benefit those individuals whose employment within the Diocese of California is discontinued for reasons beyond their control.

ELIGIBILITY:

Salary Continuation Benefits are payable to lay and clergy employees working 20 hours or more a week, and continuously employed for a minimum of 90 days, who qualify for benefits for the reasons described below.

BENEFITS:

The amount of Salary Continuation Benefits for eligible employees will be determined by length of service and average weekly salary. Eligible employees will earn one week of Salary Continuation Benefits for every calendar month employed (starting with their date of employment to a maximum of 26 weeks). Eligible employees will be entitled to a weekly benefit amount equal to 40% of their average weekly salary for the actual period of employment up to 26 weeks immediately preceding separation of employment, to a maximum weekly benefit of \$555.00.

CLAIMS ADMINISTRATION:

Determination of claimant's eligibility and approval of payment of benefits are the responsibility of a third party Claims Administrator, appointed by the Personnel Practices Commission which serves as Trustee for the Salary Continuation Benefits Program. The Claims Administrator is responsible for determining eligibility for benefits at the time a claim is first presented by the employee. Eligibility for benefits will cease when claimant gains employment.

Eligibility for continuing weekly benefits is determined by a bi-weekly audit conducted by the Claims Administrator.

Either the employee or employer may appeal eligibility determinations within 15 days of such determination being communicated in writing to both parties. Such appeals will be referred to an impartial Arbitrator experienced in unemployment benefits practices and procedures who will hear testimony by both parties in order to reach a final decision.

A details explanation of Claims Procedures follows.

- I. QUALIFICATION – Eligible employees may qualify for weekly Salary Continuation Benefits if they
 - A) Quit for a job related cause because of:
 - 1) Threat of safety in the workplace
 - 2) Reduction in working hours of 20% or more
 - 3) Work-related stress if substantiated by medical documentation
 - 4) Proven discrimination in the workplace based on that individual's race, color, sex, national origin, ancestry, or physical handicap
 - 5) Proven sexual harassment provided the individual has taken reasonable steps to preserve the working relationship
 - 6) Required resignation because of change of clergy leadership
 - 7) Completion of non-renewable fixed-term contract

- B) Were improperly discharged, provided:
 - 1) Discharge is without sufficient documented warning (at least one verbal and one written warning, except for act of gross misconduct)
 - 2) Discharge is solely based on employee's unavoidable absence or tardiness. Unavoidable absence or tardiness includes: a) death in the immediate family, b) unlawful detainment, c) hospitalization for treatment of an emergency or life threatening condition, d) due to a summons to serve jury duty or a court subpoena
 - 3) The employee is not offered similar or same position at similar or same rate of pay upon returning from authorized leave of absence
- C) Were discharged for lack of work resulting from
 - 1) Reduction in force
 - 2) Elimination of position

II. DISQUALIFICATION – Claimant will be denied weekly Salary Continuation Benefits should one or more of the following conditions occur:

- A) Discharge for gross misconduct, such as deliberate disregard for the well being of the employer and/or employees.
- B) Job abandonment defined as unreported absence of three (3) or more days
- C) Failure to Comply with employer's wishes that employee seek professional treatment for substance abuse
- D) Employee willfully made a false statement or representation, with actual knowledge of the falsity, or withheld a material fact in completing employment application or in filing a claim for Salary Continuation Benefits
- E) Voluntarily quit without work-related cause
- F) Voluntary retirement
- G) Failure to comply with the rules and policies of the employer as established by the employer's personnel policy.
- H) Temporary lack of work due to established vacation, holiday or recess periods, provided reasonable assurance of re-employment is given prior to said period
- I) Individual becomes unable to work due to a physical or mental illness or injury unrelated to his/her job

III. FILING A CLAIM

- A) Separated employee may file a claim for Salary Continuation Benefits by completing a Salary Continuation Benefits Claim form within 30 days of the official date of separation from the Diocese
 - 1. Claim Form can be obtained from the Administrator's Manual in the employer office or online at www.diocal.org/admin/
 - 2. Completed forms must be submitted to the Claims Administrator at the following address and post-marked within 30 days of Separation:
 - WageWorks
 - ATTN: Anne Buckley
 - 10375 Baldev Court, Mequon WI 53092
 - Phone: 1-888-990-5099 x 61039
 - Fax: 1-262-512-2707
 - 3. The Claims Administrator will render a benefits decision within 10 working days of receipt of the claim form

IV. FILING AN APPEAL

- A. Disputed benefits decisions may be appealed by either party within 15 days of the date indicated on the notice of decision.
 - 1. Such appeals must be submitted in writing by the appellant to the Claims Administrator at the above address
 - 2. Upon receipt of the appeal a Notice of Hearing will be issued to the claimant and the employer by an Arbitrator
 - a) Attendance at the hearing at the time and date indicated on the Notice of Hearing is mandatory
 - 3. The decision of the Arbitrator is final

BENEFITS CLAIM FORM Salary Continuation (unemployment)

1. Claimant's Name: _____

2. Mailing Address: _____

3. Telephone: _____ Social Security #: _____

4. Job Title / Description: _____

5. a) Date of Employment First day: _____ to Last day: _____

b) Date you gave notice of separation (if different from item 5a): _____

6. Employer Name: _____

Employer Address: _____

Name of Immediate Supervisor: _____

Supervisor's Contact Information: Phone #: (____) _____

Fax #: (____) _____ Email: _____

7. Are you able to work, available for work and actively seeking work?
(circle one) **YES NO**

8. Did you voluntarily quit your job?
(circle one) **YES NO**

9. Were you discharged or fired for reasons other than lack of work?
(circle one) **YES* NO** if yes, please explain: _____

Employee's Signature: _____ Date: _____

Mail completed claim form to:
WageWorks
ATTN: Anne Buckley
10375 Baldev Court, Mequon WI 53092
Phone: 1-888-990-5099 x 61039
Fax: 1-262-512-2707